Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/12/03.

I. DISPUTE

Whether there should be additional reimbursement for CPT codes L0488 and E0245, for date of service 8/21/03.

II. RATIONALE

The services in dispute were denied as, "F-Reduced according to Fee Guideline."

The Requestor states, on the Table of Disputed Services, "We feel that we are due our full billed amount for the equipment provided to this patient. The carrier has incorrectly reviewed this claim and has paid this claim at a reduced rate. These claim items were submitted based on the 1991 Fee Guidelines."

The Carriers response was untimely, per Commission Rule 133.307 (e)(3)(C) that states, "The Respondent shall file the completed request with the division and the requestor within 14 calendar days of respondent's receipt of the request." The Carrier signed for the Medical Dispute on 12/16/03, and response was received on 1/5/04. Therefore, response will not be considered.

Commission Rule 134.202 Medical Fee Guideline (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Section (c)(2)(A) states, "For Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E, J, K, and L: 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;" and Section (d) states, "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

The Medicare Fee Schedule lists reimbursement for HCPCS L0488 is $812.45 x 125% (conversion factor) = $1,015.56 (Maximum Allowable Reimbursement). Carrier paid $1,269.45. No additional reimbursement is recommended.

HCPCS E0245 is considered a "comfort or convenience item, per the Coverage Guidelines for Medicare. This is a non-covered item. Carrier paid $31.25. No additional reimbursement is recommended.

III. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 22nd day of March 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc